

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02830

CERTIFICATE OF DEATH

Reg. Dist. No.

02840

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Sev. yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 216 Washington Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 216 Washington Street				d. STREET ADDRESS 216 Washington Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Julia		First	Middle	Last	4. DATE OF DEATH March 29, 1957	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1921	9. AGE (In years last birthday) 35 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Spicer		14. MOTHER'S MAIDEN NAME Clara Harris						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-6564		17. INFORMANT Frances Harris, Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Carcinomatosis, abdominal</i>		INTERVAL BETWEEN ONSET AND DEATH 1 yr				
170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO <i>Mitastases from a breast left</i>		4 yrs				
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>loss of wt., general debility, & anemia</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Linas Road Cemetery		20f. (City or town) Linas Road, Maryland	(County)	(State)
21. I certify that I attended the deceased from Jan 1957 to Mar 29, 1957 that I last saw the deceased alive on Mar 29, 1957 , and that death occurred at 8 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Cambridge, Md.		DATE SIGNED Apr 1, 57		
ACTUAL SIGNATURE <i>Frances E. Thompson</i>		M.D.						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/1957		22c. NAME OF CEMETERY OR CREMATORIUM Linas Road Cemetery		22d. LOCATION (City, town, or county) Linas Road, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert McCallum Jr.</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR John Mace Jr.		24b. REGISTRAR'S SIGNATURE John Mace Jr.		
				DATE 4/1/57				

CERTIFICATE OF DEATH

BUREAU Y. S.

APR 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tombstone permit. File pages 1 and 2 with the registrar prior to removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02841

02831 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge				
3. NAME OF DECEASED (Type or print) Heward		First E. Middle Ball (Ball) Last	4. DATE OF DEATH Month March Day 12 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1883			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Cook		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Thomasa Ball		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Mrs. Hattie M. Ball			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion						
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____						
DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)
(State)						
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 3/18/57	
EXAMINER'S NAME (Type) Dp. John Mace Jr.	22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 3-17-57 22c. NAME OF CEMETERY OR CREMATORIAL WAUGH 22d. LOCATION (City, town, or county) CAMBRIDGE (State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE LeON W. HENRY - CAMBRIDGE	ADDRESS 24a. REC'D BY REGISTRAR DATE 3/18/57 24b. REGISTRAR'S SIGNATURE John Mace Jr.					

WITNESS EXAMINER'S CERTIFICATE OF DEATH
COMMONWEALTH OF MASSACHUSETTS

100-234

100-234

DEATH CERTIFICATE NO. 100-234

FEDERAL BUREAU OF INVESTIGATION

MAR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02842

02832

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY Dorchester Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hoopersville, Md.		d. STREET ADDRESS Hoopersville, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Hattie		First Middle Nelson		Last Booze		4. DATE OF DEATH March	Month 1	Day 19	Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1885		9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hoopersville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Edmond R. Nelson				14. MOTHER'S MAIDEN NAME Sadie Lewis						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Oscar Nelson		Address Hoopersville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				Multiple Sclerosis		INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from 2-24, 1957, to 3-1, 1957, that I last saw the deceased alive on 3-1, 1957, and that death occurred at 9 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Baumann M.D.						ADDRESS (Street, city or town, state) Cambridge		DATE SIGNED 3-2-57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 3, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.				24a. REC'D BY REGISTRAR DATE 3/4/57		24b. REGISTRAR'S SIGNATURE John Macash		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

NAME	ADDRESS	AGE	SEX	CAUSE OF DEATH
WILLIAM H. BROWN	1234 BROADWAY, TORONTO, ONTARIO	55	MALE	HEART DISEASE
DECEASED ON MARCH 7, 1957				
BUREAU V. 2				
MAR 7 1957				
RECEIVED				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

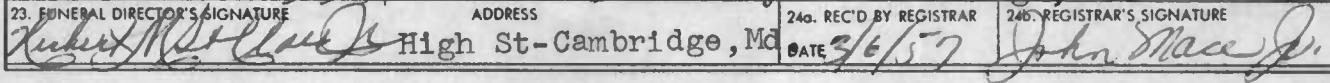
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02833

CERTIFICATE OF DEATH

02843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 9 Schoolhouse Lane			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 Schoolhouse Lane						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH March 1 1957	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1891	9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dor-Co-Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Hester Dutton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Randolph Hughes, Cambridge, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease		DUE TO (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m. 19		Month	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
21. I certify that I attended the deceased from January 10, 1956 , to March 1, 1957 , that I last saw the deceased alive on March 1, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 3-3-57			
ACTUAL SIGNATURE 				M.D. 227 Pine St-Cambridge, Md.					
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-57		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) Cambridge, Dor-Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS High St-Cambridge, Md.		24a. REC'D BY REGISTRAR 3/6/57		24b. REGISTRAR'S SIGNATURE John Maca J.			

18. **STATEMENT OF THE HIGH-SALINITY**
CHIRICAHUA CRAYFISH

BUREAU V.

MAR 8 1957

REGELVÆRDE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02844

116

02853

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 42 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		d. STREET ADDRESS 23 x 02		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CALVIN		First W.	Middle BURBAGE	Lost	4. DATE OF DEATH March 26 1957	Month March	Day 26	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/14/79	9. AGE (In years last birthday) 77	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME James Burbage		14. MOTHER'S MAIDEN NAME Mary Burbage (maiden name unknown)						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 120		17. INFORMANT Eastern Shore State Hospital records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General arteriosclerosis DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenia, hebephrenic type								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour p. o. 19 p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Berlin	(County) Md.	(State) Md.
21. I certify that I attended the deceased from Mar 15, 1953 , to Mar 26, 1957 , that I last saw the deceased alive on Mar 26, 1957 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3-26-57								
DATE SIGNED								
ACTUAL SIGNATURE Thomas J. Dredge M.D.								
PHYSICIAN'S NAME (Type) Thomas J. Dredge								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-28-57	22c. NAME OF CEMETERY OR CREMATORIUM Buckingham		22d. LOCATION (City, town, or county) Berlin				
(State) Md.								
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage Berlin								
ADDRESS MAR 29 1957								
24a. REC'D BY REGISTRAR John MacLean								
24b. REGISTRAR'S SIGNATURE								

CERTIFICATE OF DEATH

NAME

BUREAU V. 5

MAR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02834 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02845

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AT5ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL Cambridge)		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b 7 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		d. STREET ADDRESS 16 Sinclair Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cecil	Middle	Last Clark
4. DATE OF DEATH	Month March	Day 31	Year 1957
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1909
9. AGE (In years at birthday) 48 yrs.		10. IF UNDER 1YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY food packing	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 17. INFORMANT Annie May Clark	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 20 Min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John M. Clark Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10/1/57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/4/57	22c. NAME OF CEMETERY OR CREMATORIAL Waugh cemetery	22d. LOCATION (City, town, or county) Cambridge
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. Clark Jr.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE 10/1/57
			24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>

BY MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WASHINGON STAR-NEWS

X

X BUREAU V. S.

APR 3 1957

X RECEIVED

X *John G. Clegg*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02846

02853

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH a. COUNTY Dorchester			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg - Rural			b. COUNTY Dorchester		
c. LENGTH OF STAY IN 1b Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg - Rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Zion			d. STREET ADDRESS Near Zion		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Marion		First Middle Wilmer		Last Corkran	
4. DATE OF DEATH March 20	Month 1957	Day	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 21, 1869	9. AGE (in years lost birthday) 88 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Captain		10b. KIND OF BUSINESS OR INDUSTRY Steam Vessels		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Christopher C. Corkran			14. MOTHER'S MAIDEN NAME Eliza A. Andrew		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Raymond F. Corkran, Williamsburg, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 25-415 20-915 20-915 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/21, 1957, to 01/20, 1957, that I last saw the deceased alive on 3/20, 1957, and that death occurred at 7:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Harvey B. Hammer</i> M.D. ADDRESS (Street, city or town, state): <i>Preston Maryland</i> DATE SIGNED: <i>3/21/57</i> PHYSICIAN'S NAME (Type): <i>Harvey B. Hammer</i> PRESTON MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 23, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery	22d. LOCATION (City, town, or county) Federalsburg, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland			24a. REC'D BY REGISTRAR DATE March 23, 1957	24b. REGISTRAR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

MAR 26 1957

REGEL 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 02835 Item 9 FilmG213 4-3-57 et
CERTIFICATE OF DEATH

02847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 2 1/2 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 134 Locust St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Fishing Creek, Md.	
3. NAME OF DECEASED (Type or print) Edith		First Meekins	Middle Creighton
Last Creighton		Month March	Day 21
4. DATE OF DEATH Dec. 25, 1873		Year 1957	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Dec. 25, 1873		9. AGE (In years lost birthday) 84 83 yrs.	10. IF UNDER 1 YEAR Months 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	10c. BIRTHPLACE (State or foreign country) Fishing Creek, Md.
11. CITIZEN OF WHAT COUNTRY? USA		12. MOTHER'S MAIDEN NAME Rebecca Tyler	
13. FATHER'S NAME Samuel G. Meekins		14. MOTHER'S MAIDEN NAME Rebecca Tyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Homer Murphy		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 8 days.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on 3/15/17 , 19 and that death occurred at 10:00 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 136 Race St. Cambridge 3/23/57	
ACTUAL SIGNATURE Lawrence Maryanov		DATE SIGNED 3/23/57	
PHYSICIAN'S NAME (Type) Lawrence Maryanov			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 24, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Hoosier Memorial Church
22d. LOCATION (City, town, or county) Fishing Creek, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge, Md.		24a. REC'D BY REGISTRAR 3/25/57 John Race, Jr.	24b. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

NAME

BUREAU V. S

APR 1 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tombstone permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02848					
02836 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Dorchester					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					b. COUNTY Dorchester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					c. LENGTH OF STAY IN 1b Life					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Md.-Hospital					e. STREET ADDRESS 128 Park Lane					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First James	Middle	Last Dorsey	4. DATE OF DEATH 3 5 1957	Month	Day	Year							
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-2-24	9. AGE (in years last birthday) 32 yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days			Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) Dor-Co-Md.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Joseph Dorsey					14. MOTHER'S MAIDEN NAME Hattie Jones										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. unkn			17. INFORMANT 214-16-4949	Address Mrs Hattie Dorsey-Cambridge, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 week					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gastroenteritis Cirrhosis of Liver										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <i>John Mace Jr.</i>										DATE SIGNED 3/11/57					
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-57		22c. NAME OF CEMETERY OR CREMATORIAL Thompson-Town-Cemetery		22d. LOCATION (City, town, or county) Thompson Town Md.		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.M. SIC FIR JR. - High St-Camb-Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE 3/11/57		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>									

TEXAS STATE DEPARTMENT OF HIGHER EDUCATION
MEDICAL EXAMINEE CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.

MAR 12 1957

John H. Wood

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02837

CERTIFICATE OF DEATH

02849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.			c. LENGTH OF STAY IN 1b 2 Weeks		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		
3. NAME OF DECEASED (Type or print) Linnie			First	Middle	Last
4. DATE OF DEATH Mar. 11, 1957			Month	Day	Year
5. SEX Female			6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 21, 1897
9. AGE (In years lost birthday) 59 yrs.			10. IF UNDER 1 YEAR / IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salvation Army			10b. KIND OF BUSINESS OR INDUSTRY Salvation Army	11. BIRTHPLACE (State or foreign country) Talbot Co.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Hurley			14. MOTHER'S MAIDEN NAME Gertrude Allen		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None	17. INFORMANT Florence Abbott	Address E. Appleby Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO Coronary Heart Disease (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 5 min		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov M.D.			ADDRESS (Street, city or town, state) 136 Race St. DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Mar. 11, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Dor. Mem. Park	22d. LOCATION (City, town, or county) Cambridge (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service			24a. REC'D BY REGISTRAR DATE 3/15/57	24b. REGISTRAR'S SIGNATURE John Mace Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 19 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02838

02850

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18 Cambridge Md.		b. COUNTY Dorchester Co.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home 117 Locust St.				d. STREET ADDRESS 117 Locust St.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Daniel		First Daniel		Middle Garner		4. DATE OF DEATH March 1, 1957	Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1867	9. AGE (In years lost birthday) 89 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Merchant				
11. BIRTHPLACE (State or foreign country) Suwalki Poland				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Daniel Garner				14. MOTHER'S MAIDEN NAME Jennie Garner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT David I. Jacobson		Address Cambridge Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic cardio vascular renal disease 10 years+ DUE TO (c) Arteriosclerosis, generalized 10 years+								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. --- 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----		
21. I certify that I attended the deceased from 2-27-57 , 19 57 , to ####3-1 , 19 57 , that I last saw the deceased alive on ####3-1 , 19 57 , and that death occurred at 8:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eldridge H. Wolff M.D. 15 Locust Street, Cambridge, Md. DATE SIGNED 3-2-57								
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 3, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Hebrew Friendship Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR John Maas J.		24b. REGISTRAR'S SIGNATURE DATE 3/2/57		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 7 1957

REFUGEE FED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02839

CERTIFICATE OF DEATH

02851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md Hospital				d. STREET ADDRESS 14 Douglas St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lottie	Middle Jones	Last Goslee	4. DATE OF DEATH	Month 3	Day 16	Year 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8-21-1895	9. AGE (In years less birthday) 61 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY factory		11. BIRTHPLACE (State or foreign country) Dor-Co-Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William James		14. MOTHER'S MAIDEN NAME Susan Pinkett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-18-6292		17. INFORMANT Levin Fisher-Vienna, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Coronary Heart Disease (c) DUE TO Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February , 1954, to March 16 , 1957, that I last saw the deceased alive on March 16 , 1957, and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. DATE SIGNED 3-20-57							
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-20-57		22c. NAME OF CEMETERY OR CREMATORIUM Vienna Cemetery		22d. LOCATION (City, town, or county) Vienna-Dor-Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS High St-Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 3/23/57		24b. REGISTRAR'S SIGNATURE 	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02851

CERTIFICATE OF DEATH

Reg. Dist. No. 290

02852

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 9 mo. 16 das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton 20-40-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ruth	Middle Evelyn	Last Greenhawk	4. DATE OF DEATH March 8 1957	Month March	Day 8	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6-9-97	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nathaniel Clifton				14. MOTHER'S MAIDEN NAME Annie Daly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT RECORDS - Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychoneurotic Disorder, Conversion Reaction							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) E.S.S. Hospital, Cambridge, Md.	(County)	(State)
21. I certify that I attended the deceased from May 23, 1956, to March 8, 1957, that I last saw the deceased alive on March 8, 1957, and that death occurred at 6:00a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. DATE SIGNED ACTUAL SIGNATURE <i>Dr. Simon Virkutis</i> 3-8-57							
PHYSICIAN'S NAME (Type) Dr. Simon Virkutis							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 11, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery	22d. LOCATION (City, town, or county) Easton, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice L. Newman, Son</i>		ADDRESS Easton, Md.	24a. REC'D BY REGISTRAR DATE 3/11/57	24b. REGISTRAR'S SIGNATURE <i>A. J. Neerius</i> John Mac. J. S.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF NURSING-BALTIMORE 18

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

RECEIVED

MAR 15 1957

BUREAU X-8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G213 1-5-57 et

02855

CERTIFICATE OF DEATH

Reg. Dist. No.

02853

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Dor</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harlock</i>		c. LENGTH OF STAY IN 1b <i>all life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Harlock</i>		d. STREET ADDRESS <i>Academy</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>				d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Floyd</i>		First <i>N.</i>	Middle <i></i>	Last <i>Harper</i>	4. DATE OF DEATH <i>March 28, 1957</i>	Month <i>March</i>	Day <i>28</i>	Year <i>1957</i>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 31, 1889</i>	9. AGE (in years last birthday) <i>67</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance Broker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>J.S.C.</i>			
13. FATHER'S NAME <i>Thomas B. Harper</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Medford</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Mrs. Floyd N. Harper, Harlock, Md.</i>		Address <i></i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration + Acidosis</i>		DUE TO <i>163X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost. <i></i>		(b) DUE TO <i>Carcinoma of lung</i>				1 year +			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>January</i> , 19 <i>56</i> , to <i>March 28</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>March 27</i> , 19 <i>57</i> , and that death occurred at <i>4:00 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Harlock, Md.</i>		DATE SIGNED <i>3/28/57</i>	
ACTUAL SIGNATURE <i>W.C. Harrison MD</i>									
PHYSICIAN'S NAME (Type) <i>W.C. Harrison M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 3/30/57</i>		22b. DATE THEREOF <i>3/30/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington</i>		22d. LOCATION (City, town, or county) <i>Harlock, Md</i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rich. J. Hollingsby C. G. Market</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR <i>APR 3 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Quesenberry</i>			
VS A15 (4) 1SM 9/55									

CERTIFICATE OF DEATH

BUREAU V. S.

APR 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02855 CERTIFICATE OF DEATH

02854

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY		Dorchester Eastern Shore State Hosp.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md. Poconos		b. COUNTY		Warchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cambridge		c. LENGTH OF STAY IN 1b 1 Mo 3da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Poconos		d. STREET ADDRESS		RD-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Eastern Shore State Hosp.				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First John		Middle H.		Lost Heel		4. DATE OF DEATH		Month March		Day 2		Year 1957	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.			
M-		W-				6-7-1880		76 yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Farmer		Farmer		Snow Hill Md.		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
John Hill		Jane Pettitt													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
No.		None		John Heel		Poconos									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH									
422.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Arterio-sclerosis - Generalized		1-27-57									
		DUE TO (c) Paraplegia (Throat)				3-2-57									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		EDema Lower Extremities													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I attended the deceased from 1-27-1957 to 3-2-1957, that I last saw the deceased alive on 3-1-1957, and that death occurred at 12:15 P.M. from the causes and on the date stated above.															
ACTUAL SIGNATURE		M.D.		Eastern Shore State Hosp.		ADDRESS (Street, city or town, state)		DATE SIGNED							
PHYSICIAN'S NAME (Type)		Edwin J. Ward													
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)							
Burial		3-5-57		PARKSLEY CEMETERY		PARKSLEY		VIRGINIA							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
Henry L. Watson		Pocomoke, Md.		MAR 7 1957		John Macay									

CERTIFICATE OF DEATH

FORM NO. 300-1
REV. 1-1957

RECEIVED

BUREAU Y. S.

MAR 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02857 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylors Island		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elsie		First Edith	Middle Hooper
4. DATE OF DEATH Last Mar.	Month 13	Day 1957	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1901
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Webster Stanley	
14. MOTHER'S MAIDEN NAME Fannie Thompson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 218-05-6291		17. INFORMANT Address Minnie Dennis, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		DATE SIGNED 3/15/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/1957	
22c. NAME OF CEMETERY OR CREMATORIAL Taylors Island		22d. LOCATION (City, town, or county) (State) Taylors Island, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert M. Bell Jr.</i>		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR DATE 3/15/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

BUREAU V. 2

MAR 19 1957

RECEIVED

John M. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02856

02840

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b
RURAL and give nearest town

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

3 / 13 1957

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
from birthday)
yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Internal hemorrhage (Thoracic)

INTERVAL BETWEEN
ONSET AND DEATH

200.1

1 day

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

Lymphosarcoma left lung

? day

(b)

Seekemin - lymphatic

?

DUE TO

(c)

DUE TO

CERTIFICATE OF DEATH

BUREAU V. 2

MAR 19 1957

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 02841 CERTIFICATE OF DEATH

02857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dor.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 East New Market Md.		d. STREET ADDRESS East New Market Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Mariam	Middle Simpson	Last Jackson	4. DATE OF DEATH Mar.	Month 11	Day 19	Year 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1913	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shirt Factory		10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Andrew Simpson				14. MOTHER'S MAIDEN NAME Mary Della					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-9057		17. INFORMANT Harry Jackson		Address Hurlock Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Mreamo Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause last.</u> (b) Chronic Nephritis DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH 5 days years?									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 311		20f. (City or town) 311		(County) 311	(State) 311
21. I certify that I attended the deceased from 311 , 19 57 , to 311 , 19 57 , that I last saw the deceased alive on 311 , 19 57 , and that death occurred at 311 , 19 57 , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) W. H. Hanks									
ACTUAL SIGNATURE W. H. Hanks									
PHYSICIAN'S NAME (Type) W. H. Hanks									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Dor. Mem. Park		22d. LOCATION (City, town, or county) Cambridge Md.			
(State) Cambridge Md.									
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE 3/15/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.			

BUREAU Y. S.

JUN 19 1957

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02842

CERTIFICATE OF DEATH

02858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 High Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Henry	4. DATE OF DEATH Lost Jackson Month Mar. Day 15, Year 1957
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 16, 1851
9. AGE (In years from birth) 105	10. IF UNDER 1 YEAR Months 105	11. IF UNDER 24 HRS. Days 105	12. IF UNDER 24 HRS. Hours 105
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Pinkett	14. MOTHER'S MAIDEN NAME Annie A. Jackson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. *****	17. INFORMANT Sudie Gibson, Cambridge, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure INTERVAL BETWEEN ONSET AND DEATH 2 weeks DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis C.V. Disease ? DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/29/1956 to 3/1/57 , that I last saw the deceased alive on 3/1/57 , and that death occurred at Cambridge, Md. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE John Mace Jr. DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/19/1957	22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hubert McElroy Jr.	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE 3/19/57	24b. REGISTRAR'S SIGNATURE John Mace Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 3300M11AB-172478 30 7/31/1980 01A 2 0/4A 2/29/1980

RECEIVED
MAR 22 1957
BUREAU V. S.

MAR 22 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02859

Item 1b Film G212 3-29-57 et

02858

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester County		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN 1b 6 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Goldsboro St. Easton, Md.	
3. NAME OF DECEASED (Type or print) Marjorie		First S.	Middle Jaynes.
4. DATE OF DEATH 3/20.57		Month 3	Day 20
5. SEX F.		6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 1, 1879		9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) Maryland.		12. IF UNDER 24 HRS. Days 0	13. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY own home	
13. FATHER'S NAME Harten.		14. MOTHER'S MAIDEN NAME "No records"	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Adam Royer.		Address Easton, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX		INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)		General Arteriosclerosis 5 years +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE W.C. Harrison MD		ADDRESS (Street, city or town, state) Hurlock, Md. DATE SIGNED 3/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF March 22, 57.	22c. NAME OF CEMETERY OR CREMATORIAL Oxford.
22d. LOCATION (City, town, or county) Oxford, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John L. Lark		24a. REC'D BY REGISTRAR DATE MAR 26 1957	24b. REGISTRAR'S SIGNATURE A. H. Redman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
MAR 26 1957				
BUREAU V. S.				
RECEIVED				

87,300MTAG-51

1973-05-12

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WATTE MISS 13125

WISCONSIN'S COUNCIL FOR ECONOMIC EDUCATION

1950-1951 2nd year snake hatched

20712238 2378418

$\tau \in \mathbb{R}^n$, $\mathcal{C} \in \mathbb{R}^{n \times n}$, $\mathcal{L} \in \mathbb{R}^{n \times n}$

1933-34 Bureau A. E.

MAR 12 1957

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02861

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b lyr. 2 mo. 13	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) da. Caroline County 05x12 ✓	
3. NAME OF DECEASED (Type or print) First George		d. STREET ADDRESS R. F. D.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Rural			
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1889	
9. AGE (In years at birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Unk.	
13. FATHER'S NAME Jessie Passawters		14. MOTHER'S MAIDEN NAME Eliza Legates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Gilbert Passawters		Address Denton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO <input checked="" type="checkbox"/> Cerebral Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. Brain Symdrome w. psychotic recations DUE TO <input type="checkbox"/> Malnunutrition (c)			
INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month. Day. Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/3/1957, to 3/2/57, 19, that I last saw the deceased alive on 3/7/1957, and that death occurred at 11.10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edwin J. Ward</i> PHYSICIAN'S NAME (Type) Edwin J. Ward ADDRESS (Street, city or town, state) Cambridge, Maryland DATE SIGNED			
22a. BURIAL OR CREMATION, REMOVAL (Specify) 3/13/1957		22b. DATE THEREOF 3/13/1957	
22c. NAME OF CEMETERY OR CREMATORIAL Blossom Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Ward</i>		24a. ADDRESS Federalsburg, Md.	
24b. REC'D BY REGISTRAR DATE, 3/23/57		24c. REGISTRAR'S SIGNATURE <i>John May Jr.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF CALIFORNIA
DEPARTMENT OF JUSTICE
CERTIFICATE OF DEATH

U. S. POSTAL SERVICE
BUREAU

MAR 26 1957

RECEIVED
FBI

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.		d. STREET ADDRESS E. Appleby Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In car on Holland ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF -DECEASED (Type or print) Leon		First T.	Middle Peters	Last Mar.	4. DATE OF DEATH 25	Month Mar.	Day 19	Year 57
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1905	9. AGE (In years last birthday) 51	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jos eph Peters		14. MOTHER'S MAIDEN NAME Nettie Davey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Leon Peters		17. INFORMANT E. Appleby Ave.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary occlusion				Instant		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)								
DUE TO 420.1								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/26/57		
EXAMINER'S NAME (Type) John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 27, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE 3/27/57		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEDDING EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02863

02844

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.		d. STREET ADDRESS 119 Talbot Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Howard		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1900		9. AGE (In years from birthday) 57 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Broker		10b. KIND OF BUSINESS OR INDUSTRY Produce Broker		11. BIRTHPLACE (State or foreign country) Neck Dist. Dor. Co.		12. CITIZEN OF WHAT COUNTRY? U SA.		
13. FATHER'S NAME Howard C. Reed				14. MOTHER'S MAIDEN NAME Grace Warfield				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-6803		17. INFORMANT Margaret Marie Reed Cambridge Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)				Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 9 hrs		
				Coronary Heart Disease		2 yrs		
				Diabetes mellitus		10 yrs		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/> p. m. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from _____, 3/18/57, 19_____, to _____, 3/27, 19_____, that I last saw the deceased alive on _____, 3/27, 19_____, and that death occurred at _____, 9 AM, from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Lawrence Maryanov M.D.		ADDRESS (Street, city or town, state) 136 Race St Cambridge Md DATE SIGNED 3/28/57						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 29, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE 3/29/57		24b. REGISTRAR'S SIGNATURE J. La. Mace, Jr.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02864

02861

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH o. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vienna Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rhodesdale - Rural	
3. NAME OF DECEASED (Type or print) First Charlie Middle Linwood Last Rideout		d. STREET ADDRESS Vienna Road	
4. DATE OF DEATH March 7		Month 7	Day Year 1957
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 27, 1887
9. AGE (In years from birth) 70 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Johnson	
14. MOTHER'S MAIDEN NAME Katie Lake		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 214-07-9985		17. INFORMANT Mrs. Mildred Jones, Rhodesdale, Md., R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr + General Arteriosclerosis 1 yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 5</u> , 1957, to <u>March 7</u> , 1957, that I last saw the deceased alive on <u>March 5</u> , 1957, and that death occurred at 10:30PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hurstock, Md. DATE SIGNED 3/8/57	
ACTUAL SIGNATURE W.C. Harrison PHYSICIAN'S NAME (Type)		22d. LOCATION (City, town, or county) Near Rhodesdale, Md. (State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF March 11, 1957	
22g. NAME OF CEMETERY OR CREMATORIUM Reid's Grove Cemetery		24a. REC'D BY REGISTRAR DATE March 11, 1957	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24b. REGISTRAR'S SIGNATURE Mrs. Chat. W. Hastings	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02865

02845

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Dorchester Co.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge, Md.

c. LENGTH OF STAY IN 1b

10 Days

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

b. STATE

Md.

b. COUNTY

Dorchester Co.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

13 Cambridge Md.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Cambridge Md. Hospital

d. STREET ADDRESS

12 Glasgow Ave.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
Frank

Middle

Last

4. DATE
OF
DEATHMonth
MarchDay
7
Year
1957

S. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)70
yrs.10. IF UNDER 1 YEAR
Months11. IF UNDER 24 HRS.
Days

Hours

Min.

Male

White

WIDOWED DIVORCED

June 17, 1886

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Director of Public Relations

Cambridge Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Robbins

14. MOTHER'S MAIDEN NAME

Mary Jane Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
Yes

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

World War I

220-01-76

Mr. William Shaw

Cambridge, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Tremor

INTERVAL BETWEEN
ONSET AND DEATH

3 days

331X

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

DUE TO

(b)

Cerebrovascular Hemorrhage

2 wks

DUE TO

(c)

Arteries

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

260X Diabetes

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 19, 1956, to March 7, 1957, that I last saw the deceased alive on 3-7-1957, and that death occurred at 8:30 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

W. H. Brumann

M.D.

Cambridge Md. 2-8-57

PHYSICIAN'S
NAME (Type)

W. H. Brumann

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Burial

March 9, 1957

Dorchester Mem. Park

Cambridge

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

LeCompte Funeral Service Cambridge, Md.

3/22/57 John Macd.

81-39047148-170430Z NOV 1983 000000Z NOV 1983

BUREAU Y. S.

MAR 26 1957

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02867

02846 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester						
c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 405 Trenton St.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First Nancy	Middle Lee	Last Rosetta					
4. DATE OF DEATH	Month March	Day 15, 1957	Year 19					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1957					
9. AGE (In years last birthday) yrs. Months		10. IF UNDER 1 YEAR Months						
11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours						
13. FATHER'S NAME Charles B. Rosetta Jr.		14. MOTHER'S MAIDEN NAME Naomi Willey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No						
17. INFORMANT Charles B. Rosetta Jr., 405 Trenton St., Cambridge		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u>								
DUE TO <u>761.0</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause last.</u>								
(b) <u>Anoxemia due to prolapsed cord</u>								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.		Month --	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) ---	(County)	(State)
21. I certify that I attended the deceased from <u>March 14</u> , 1957, to <u>March 15</u> , 1957, that I last saw the deceased alive on <u>March 15</u> , 1957, and that death occurred at <u>3:50AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE	<u>Eldridge H. Wolff</u> M.D. <u>15 Locust Street, Cambridge, Md. 3-16-57</u>							
PHYSICIAN'S NAME (Type)	<u>Eldridge H. Wolff, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF March 16, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery	22d. LOCATION (City, town, or county) Cambridge, Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Leonard</u> , Cambridge, Md.	ADDRESS 2067235 XV4	24a. REC'D BY REGISTRAR DATE <u>3/20/57</u>	24b. REGISTRAR'S SIGNATURE <u>John Maughan</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

81.3907185-111459 80 THERMOTACIC STATE CHARTS

BUREAU V. S.

MAR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02863

CERTIFICATE OF DEATH

02866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 75 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Locust St.		d. STREET ADDRESS 201 Locust St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Bertha		First Bertha	Middle May	Last Robinson	4. DATE OF DEATH March 5, 1957	Month March	Day 5	Year 1957
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1880	9. AGE (In years less birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Public School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teacher		11. BIRTHPLACE (State or foreign country) Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Everett Robinson		14. MOTHER'S MAIDEN NAME Sarah Montgomery						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or date of service) No	17. INFORMANT 107 Muir Street, Mrs. E. M. Layton, Cambridge, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Palmonary Embolism		DUE TO Coronary thrombosis			INTERVAL BETWEEN ONSET AND DEATH Instantly			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) Arteriosclerotic CVD complete block		DUE TO Arteriosclerotic CVD complete block			INTERVAL BETWEEN ONSET AND DEATH Mar 4, 57			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Heart Valvular deivation 2 weeks			20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Mar 1, 1957 to Mar 5, 1957 , that I last saw the deceased alive on Mar 4, 1957 , and that death occurred at Cambridge, Md. from the causes and on the date stated above. ACTUAL SIGNATURE James L. Thompson M.D. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED Mar 7, 1957								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Mar. 7, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shewar.		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 3/11/57		24b. REGISTRAR'S SIGNATURE John MacLean Jr.		

BUREAU V. S.

MAR 13 1957

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02864 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02868

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Hoopersville

c. LENGTH OF STAY IN 1b

44

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Roadside House

3. NAME OF
DECEASED
(Type or print)

Sangston

First

Middle

Last

4. DATE
OF
DEATH

Ross

March

9

19 57

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 12, 1913

9. AGE (In years
last birthday)

44

yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Waterman

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Ross

14. MOTHER'S MAIDEN NAME

Ida T. Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

Yes

(If yes, give war or dates of service)

ARMY - 1936

16. SOCIAL SECURITY NO.

216-01-6201

17. INFORMANT

William Ross—Hoopersville-Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute Heart failure

INTERVAL BETWEEN
ONSET AND DEATH

?

322.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

Exhaustion

?

DUE TO

Acute alcoholism

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection , Inquiry , and find that
death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined cause .ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

John Mace Jr.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

3/11/57

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

3/11/57

22b. DATE THEREOF

Hoopersville-Md.

22d. LOCATION (City, town, or county)

Dorchester

(State)

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

LEON W. HENRY

ADDRESS

Camb. Md.

24a. REC'D BY REGISTRAR

DATE 3/11/57

24b. REGISTRAR'S SIGNATURE

John Mace Jr.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

VS. A15ME(5)
5M 9/55'

THE LIGER EXPLOSIONS ARE THE LARGEST EXPLOSIONS IN THE HISTORY OF EACH.

BUREAU V. 5

MAR 19 1957

REGELIV EU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02862 CERTIFICATE OF DEATH

02869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Full life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hosp.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick Ruark</u>		d. STREET ADDRESS <u>201 Glasgow</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mercant</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	9. AGE (In years last birthday) <u>85</u> yrs.
13. FATHER'S NAME <u>Major Ruark</u>	14. MOTHER'S MAIDEN NAME <u>✓</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>422-2</u>	17. INFORMANT <u>Son - Henry Ruark</u>	Address <u>201 Glasgow St.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <u>Arterio-Sclerosis generalized</u>			
DUE TO (b) <u>Malnutrition - Chronic Brain Syndrome</u>			
DUE TO (c) <u>Underlying Sub acute infection</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u>None</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cambridge</u>	20f. (City or town) (County) <u>Cambridge</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>Feb 20, 1957</u> to <u>Mar 18, 1957</u> , that I last saw the deceased alive on <u>Mar 18, 1957</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>Edwin J. Ward</u>			
ACTUAL SIGNATURE <u>Edwin J. Ward</u>	M.D.		
PHYSICIAN'S NAME (Type) <u>Edwin J. Ward</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL Mar 21, 1957</u>	22b. DATE THEREOF <u>Mar 21, 1957</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Dor. Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service - Cambridge, Md.</u>	ADDRESS	24a. REC'D BY REGISTRAR <u>3/19/57</u>	24b. REGISTRAR'S SIGNATURE <u>John Brack</u>

MAR 22 1957

SEGELVÆD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04021

02847

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 East New Market - Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 1 Thompsonstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sarah		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year 1957
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1880	9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Isaac Molock			14. MOTHER'S MAIDEN NAME Frances Nichols					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Algie Sampson, East New Market, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Anemia								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from 24 October, 1955, to 30 March, 1957, that I last saw the deceased alive on March 30, 1957, and that death occurred at 2:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. -4-2-57 DATE SIGNED								
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		22d. LOCATION (City, town, or county) Near Rhodesdale, Maryland (State)						
PHYSICIAN'S (Name & Type) J. Edwin Fassett, M.D.		22e. NAME OF CEMETERY OR CREMATORIAL Reid's Grove Cemetery						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 2, 1957		22c. ADDRESS J.J. Frampton and Son, Federalsburg, Maryland		22d. LOCATION (City, town, or county) Near Rhodesdale, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE 4/5/57 24b. REGISTRAR'S SIGNATURE <i>John Macay</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 11 1957

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02870

02848

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		d. STREET ADDRESS 300 Locust St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sadie	Middle Parks	Last Schaffer	4. DATE OF DEATH March 2, 1957	Month March	Day 2	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH April 19, 1879	9. AGE (In years last birthday) 77	10. IF UNDER 1 YEAR Months 77	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George S. Parks			14. MOTHER'S MAIDEN NAME Mary Jane Meekins				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mildred LeCompte		Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure							
570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Myocardic Thrombosis							
DUE TO (c) Generalized Arteriosclerosis							
INTERVAL BETWEEN ONSET AND DEATH 16 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Residual RT Hemiplegia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/10 , 1944, to 3/1 , 1957, that I last saw the deceased alive on 3/1 , 1957, and that death occurred at 3:30 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 104 Locust St. DATE SIGNED Cambridge, Maryland							
ACTUAL SIGNATURE W. H. Hanks, M.D.							
PHYSICIAN'S NAME (Type) W. H. Hanks, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 5, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge, Md.			
24a. REC'D. BY REGISTRAR DATE 3/6/57				24b. REGISTRAR'S SIGNATURE John Mace, Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y.

MAR 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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02849

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Nicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MADELLA 22 x 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAMBRIDGE-MARYLAND Hosp., Inc.		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle W.	Last Smith	4. DATE OF DEATH MAR 30 1957	Month MAR	Day 30	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-77	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Powhaten Smith		14. MOTHER'S MAIDEN NAME MARY DUMDEE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Floessie M. Smith (wife)		Address HOSPITAL ADMISSION Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-VASCULAR RENAL DISEASE		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS					
442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 MAR. 1957 to 30 MAR. 1957 that I last saw the deceased alive on 29 MAR. 1957 , and that death occurred at 5:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Walter E. Gunby Jr. 105 CHURCH ST. DATE SIGNED ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR. CAMBRIDGE MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF MAR 31, 1957	22c. NAME OF CEMETERY OR CREMATORIAL OPO Fellows Green	22d. LOCATION (City, town, or county) Laurel, Del. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE N. L. Disharoon, Laurel, Del.		ADDRESS APR 9 1957	24a. REC'D BY REGISTRAR DATE John Mee, Jr.				
24b. REGISTRAR'S SIGNATURE							

WISCONSIN STATE GOVERNMENT OF HENRY - SAWMILL

CERTIFICATE OF DEATH

DEATH

CERTIFICATE

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BUREAU V. S

APR 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, removal, or removal.

02865 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02871

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 61 Park Lane		13. Cambridge	
3. NAME OF DECEASED (Type or print) Mary		First Etta	Middle Stafford
4. DATE OF DEATH March 17 1957	Month March	Day 17	Year 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 6-28-1929
8. ADDRESS 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) 27 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dor-Co-Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Amos Stafford	
14. MOTHER'S MAIDEN NAME Mary Etta Edphas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Joseph Amos Stafford-61 Park Lane-Camb. Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 1 week			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Dorchester	(County) Maryland	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John Mace Jr.</i>	DATE SIGNED 3/23/57		
EXAMINER'S NAME (Type) Dr. John Mace Jr.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 3-21-57	22c. NAME OF CEMETERY OR CREMATORIUM Rock Cemetery	22d. LOCATION (City, town, or county) (State) Rock-Dorchester-Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert S. Clark</i>	ADDRESS High St. Camb. Md.	24a. REC'D BY REGISTRAR DATE 3/23/57	24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>

WISCONSIN STATE DEPARTMENT OF NATURAL RESOURCES
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME
ADDRESS
CITY
STATE
ZIP
PHONE NUMBER

NAME
ADDRESS
CITY
STATE
ZIP
PHONE NUMBER

BUREAU V. S.

MAR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02866

CERTIFICATE OF DEATH

Reg. Dist. No.

02872

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Delaware Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dover Easton		d. STREET ADDRESS South Aurora Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Convalescent Home				d. STREET ADDRESS South Aurora Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) AGNES		First LEAH	Middle LEAH	Last STEWART	4. DATE OF DEATH March 12 1957	Month March	Doy 12	Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 11-14-1872	9. AGE (In years lost birthday) 84 yrs.	IF UNDER 1 YEAR Months 84	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Thomas Stewart			14. MOTHER'S MAIDEN NAME Anastasia Richardson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Glasgow Convalescent Home Records, Cambridge, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 INTERVAL BETWEEN ONSET AND DEATH 10-15 mins.								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Coronary Sclerosis 3 months + DUE TO Arteriosclerotic cardio vascular renal disease 3 months + (c) with congestive failure 3 months +								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adeno-carcinoma of breast, left, with operation 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---						
20c. TIME OF INJURY Hour o. m. p. m. ---	Month 19	Doy 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) ---	(County) ---	(State) ---	
21. I certify that I attended the deceased from January 8, 1957 to March 12, 1957 that I last saw the deceased alive on March 7, 1957 , and that death occurred at 5:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eldridge H. Wolff, M.D. DATE SIGNED 15 Locust Street, Cambridge, Md. 3-13-57.								
ACTUAL SIGNATURE <i>Eldridge H. Wolff, M.D.</i>	PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 3-14-57	22c. NAME OF CEMETERY OR CREMATORIUM Springhill Cemetery			22d. LOCATION (City, town, or county) Easton			(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Clark Funeral Home				ADDRESS Easton, Maryland	24a. REC'D BY REGISTRAR 3/16/57		24b. REGISTRAR'S SIGNATURE John Macph.	

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MAR 19 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02850

CERTIFICATE OF DEATH

Reg. Dist. No. 02873

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Baby Boy		First	Middle	Last	4. DATE OF DEATH Thompson	Month	Day	Year
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-57	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Dor-Co-Md.		12. CITIZEN OF WHAT COUNTRY? USA		
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13. FATHER'S NAME James Brummell		14. MOTHER'S MAIDEN NAME Evangeline Thompson		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Essie Thompson-Cambridge, Md.				

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis		INTERVAL BETWEEN ONSET AND DEATH
DUE TO 762.5		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Prematurity		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from alive on March 6, 1957 and that death occurred at		19. March 6, 1957 to March 6, 1957 that I last saw the deceased
		ADDRESS (Street, city or town, state)

ACTUAL SIGNATURE <i>J. Edwin Fassett</i>	M.D.	227 Pine St-Cambridge, Md.	-3-9-57
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-9-57	22c. NAME OF CEMETERY OR CREMATORIUM Salem Cemetery	22d. LOCATION (City, town, or county) Salem, Md.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert McAllister</i>	ADDRESS 227 Pine St-Cambridge, Md.	24a. REC'D BY REGISTRAR DATE, 3/11/57	24b. REGISTRAR'S SIGNATURE John Mace Jr.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH

DEATH CERTIFICATE

BUREAU V. A

MAR 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02867

CERTIFICATE OF DEATH

02874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford Md.		c. LENGTH OF STAY IN 1b 22 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Woolford Md.		d. STREET ADDRESS Woolford Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woolford Md.				d. STREET ADDRESS Woolford Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Jones	Last Thompson	4. DATE OF DEATH March	Month 13	Day 19	Year 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 15, 1872	9. AGE (In years lost birthday) 84	IF UNDER 1 YEAR Months 84	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Church Creek Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Asbury D. Jones				14. MOTHER'S MAIDEN NAME Sarah Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Edwin Bramble		Address Woolford Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) LEFT CEREBRAL HEMORRHAGE CEREBRAL ARTERIOSCLEROSIS GENERALIZED ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 2 days.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 104 Locust St.	20f. (City or town) Cambridge	(County) Maryland	(State) MD.
21. I certify that I attended the deceased from 3/13/57 to 3/13/57 that I last saw the deceased alive on 3/13/57 , and that death occurred at 7 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE M. H. Hanks ADDRESS (Street, city or town, state) Cambridge, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 16, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Old Trinity Church		22d. LOCATION (City, town, or county) Church Creek	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 3/18/57		24b. REGISTRAR'S SIGNATURE John Macfar	

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	DEATH PLACE	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
BUREAU V. S.						
MAY 29 1957						
RECEIVED						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02875		
02868 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY Dorchester					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek			c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek			d. STREET ADDRESS 1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Keath Elvis Yuvonne Travers					First	Middle	Last	4. DATE OF DEATH Mar. 16, 1957	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Jan. 8, 1957	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Dorchester County, Md.						
13. FATHER'S NAME Vernon Molock					14. MOTHER'S MAIDEN NAME Julvadia Travers							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Julvadia Travers, Church Creek, Md.		12. CITIZEN OF WHAT COUNTRY? USA						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia												
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute respiratory infection										1 day		
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>John Mace Jr.</i>										DATE SIGNED 3/17/57		
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/1957		22c. NAME OF CEMETERY OR CREMATORIUM Linas Road		22d. LOCATION (City, town, or county) Linas Road, Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. Seelbach Jr.</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR 3/17/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.						
2067135X5												

BUREAU V. S.

MAR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02863 CERTIFICATE OF DEATH

02876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford		c. LENGTH OF STAY IN 1b 17 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First ADA	Middle NEAL	Last WARREN	4. DATE OF DEATH March, 9	Month March	Day 9	Year 1957
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1884	9. AGE (In years lost birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME John H. Neal	14. MOTHER'S MAIDEN NAME Josephine Wheatley	Address Mrs. Florence Neal Mills, Woolford, Md.
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. XXX	17. INFORMANT Mrs. Florence Neal Mills, Woolford, Md.	INTERVAL BETWEEN ONSET AND DEATH Unknown
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Carcinoma of stomach	
(b) DUE TO Mal nutrition		1 yr.	
(c) DUE TO Partial obstruction stomach		6 mos.	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Active - Schizos generalized		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>June</u> , 1956, to <u>Mar. 9</u> , 1957, that I last saw the deceased alive on <u>Mar. 8</u> , 1957, and that death occurred at <u>2:25 P.M.</u> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) Cambridge, Md.	DATE SIGNED Mar 11, '57
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ACTUAL SIGNATURE James U. Thompson	M.D.
PHYSICIAN'S NAME (Type) James U. Thompson	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 12, 1957 Hollywood	22c. NAME OF CEMETERY OR CREMATORIUM XX	22d. LOCATION (City, town, or county) Harrington, Del.
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23. FUNERAL DIRECTOR'S SIGNATURE (Mrs.) R. H. Boyer, Harrington, Del.	ADDRESS	24a. REC'D BY REGISTRAR DATE 3/11/57	24b. REGISTRAR'S SIGNATURE John Mace Jr.
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CERTIFICATE OF DEATH

State of Wisconsin

REGISTRATION NO.

MATERIAL



REGISTRATION NO.

NAME

REGISTRATION NO.

BUREAU V. S.

MAR 13 195

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02877

02870

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b Eastern Shore State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
3. NAME OF DECEASED (Type or print) LAURA AMANDA		First DENNIS		Middle WHITE		4. DATE OF DEATH March 20		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/30/74		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pittsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Hiram Dennis		14. MOTHER'S MAIDEN NAME Mathilda Littleton							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Mae Downs—Pittsville, Maryland Eastern Shore State Hospital records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 831X		Cerebral hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 6 days			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Cerebral arteriosclerosis							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 17</u> , 1957, to <u>March 20</u> , 1957, that I last saw the deceased alive on <u>March 20</u> , 1957, and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Thomas J. Dredge</u>				ADDRESS (Street, city or town, state) State Hospital, Cambridge, Maryland		DATE SIGNED 3-20-57			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>		Eastern Shore State Hospital—Cambridge, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 23, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Line Church Cemetery		22d. LOCATION (City, town, or county) Near Pittsville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.		ADDRESS		24a. REC'D. BY REGISTRAR DATE 3/23/57		24b. REGISTRAR'S SIGNATURE John Macay			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

MAR 26 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02871 CERTIFICATE OF DEATH

Reg. Dist. No.

02878

1. PLACE OF DEATH o. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b 55 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 Boundary Ave.		d. STREET ADDRESS 207 Boundary Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jennie	Middle Ethel	Last Wroten
4. DATE OF DEATH	Month March 15, 1957	Day 19	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1883
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) Brookview, Dor. Co.	
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME William F. Collison		14. MOTHER'S MAIDEN NAME Sarah Bassett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 214-07-8787	
17. INFORMANT Ethel Cannon, 207 Boundary Ave., Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(c) DUE TO		4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aplastic Anemia		4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 31/15	
(County)		(State)	
21. I certify that I attended the deceased from 21/10, 1950, to 31/15, 1957, that I last saw the deceased alive on 31/15, 1957, and that death occurred at M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE W. H. Hanks		DATE SIGNED 3/15/57	
PHYSICIAN'S NAME (Type) W. H. Hanks		22. BURIAL, CREMATION, REMOVAL (Specify) Mar. 17, 1957	
22b. DATE THEREOF Mar. 17, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery	
22d. LOCATION (City, town, or county) Cambridge		(State) Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth L. Thomas, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 3/20/57	
		24b. REGISTRAR'S SIGNATURE John MacL.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. E.
MAR 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02851

CERTIFICATE OF DEATH

02879

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge - Maryland Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna	
3. NAME OF DECEASED (Type or print) Samuel		First J.	Middle Young
4. DATE OF DEATH March 17 1957		5. SEX Male	6. COLOR OR RACE Colored
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH November 25, 1883	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
10c. BIRTHPLACE (State or foreign country) East New Market, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Young		14. MOTHER'S MAIDEN NAME Mary Etta Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Lavinia J. Young, Vienna, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 17, 1957, to March 17, 1957, that I last saw the deceased alive on March 17, 1957, and that death occurred at _____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED ACTUAL SIGNATURE _____ M.D. 227 Pine St-Cambridge, Md. -3-21-57			
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 21, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL East New Market Cemetery		22d. LOCATION (City, town, or county) (State) East New Market, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE 3/23/57	
ADDRESS Federalsburg, Maryland		24b. REGISTRAR'S SIGNATURE John Maech	

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BUREAU V. S.
MAR 28 1957

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